		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
15G442		B. WING			12/09/2015		
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00	Dates of Survey 12/3/15, 12/4/15 Facility Number Provider Number AIMS Number: These deficience findings in according to the survey of the surv	r: 000956 er: 15G442 100244760 ies also reflect state rdance with 460 IAC 9. of this report completed	W	0000			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7		W	0125	W125: The facility must ensur the rights of all clients. Therefore, the facility must all and encourage individual clien to exercise their rights as clien	ow	01/08/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G442	B. WI	ING		12/09/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					VING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		ual rights were not			of the facility, and as citizens		
	1	icting their access to soda			the United States, including the right to file complaints, and the		
	and snacks.				right to due process.	ie	
					right to due process.		
	Findings include	: :			Corrective Action: (Specific	:):	
					All client plans have been	,	
	Observations we	ere conducted at the			reviewed and none of the clien	nt's	
	group home on 1	12/2/15 from 6:00 AM			requires restriction of soda an	d	
	through 8:00 AN	A. At 6:00 AM, 6 cans of			snacks. The soda and snacks	are	
	soda were on the kitchen table with no				no longer locked and clients h	ave	
	clients present at the table. At 6:45 AM,				free access. The Residential		
	client #4 was seated at the table and				Manager and all staff will be		
	placed one can o	of soda in her lunch bag			in-serviced on client rights.		
	for day services.	Client #4 indicated she					
	gets to take one	can of soda to workshop					
	1 -	n day and one soda in the			How others will be identified	1.	
		the home. Client #4			(Systemic): The QIDP will vi		
	_	la and snacks were kept			the home at least twice weekly		
		set. The kitchen closet			ensure that clients are being	,	
	was secured with				encouraged to exercise their		
		- w F			rights and there are no		
	Interview with c	lient #4 on 12/2/15 at			restriction's in place that are r	not	
		ted staff (unspecified)			warranted or addressed in clie	nt	
		ans of soda on the table			program plans. The Program		
	_	pack in their lunches.			Manager will visit the home a		
		ted the soda and snack			least once a week to ensure th		
					clients are being encouraged t	0	
	_	a locked closet. When			exercise their rights and that		
		ld keep soda or snacks			there are no restrictions in pla	ce	
	that she purchased, client #4 stated, "Yes,				that are not warranted or		
		a and snacks. Staff keep			addressed in client program		
	it in the closet."				plans.		
					Measures to be put in place	:	
		taff #1 on 12/2/15 at 6:50			All client plans have been	-	
	I AM indicated so	da and snacks are kept in	1		Pand nave coon		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED		
15G442		B. WING 12/09/2015)15		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			402 EW	/ING LN		
		LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		Staff #1 indicated clients			reviewed and none of the clien		
		5, #6, #7 and #8 did not			requires restriction of soda and		
	have soda or sna	cks in their personal			snacks. The soda and snacks a		
	bedrooms to ens	ure pest control.			no longer locked and clients ha	ive	
					free access. The Residential		
	1. Client #1's rec	ord was reviewed on			Manager and all staff will be		
		PM. Client #1's ISP			in-serviced on client rights.		
		oort Plan) dated 5/15/15,					
	` .	Support Plan) dated					
	5/15/15, CFA (C				Monitoring of Corrective		
		•			Action: The QIDP will visit th	e	
	Functional Assessment) dated 6/1/15 or diet orders as listed on her 11/26/15				home at least twice weekly to		
					ensure that clients are being		
		ers did not indicate			encouraged to exercise their		
		f the assessed need to			rights and there are no		
	restrict client #1'	s access to soda or			restriction's in place that are no	ot	
	snacks.				warranted or addressed in clier		
					program plans. The Program		
	2. Client #2's rec	ord was reviewed on			Manager will visit the home at		
	12/2/15 at 10:51	AM. Client #2's ISP			least once a week to ensure that		
	dated 3/29/15. B	SP dated 5/7/15 or diet			clients are being encouraged to	,	
	· ·	ed on her 11/26/15			exercise their rights and that		
		ers did not indicate			there are no restrictions in place	e	
		f the assessed need to			that are not warranted or		
		s access to soda or			addressed in client program		
		s access to soda of			plans.		
	snacks.						
	0.01						
		ord was reviewed on					
		AM. Client #3's ISP			Completion date: 01/08/2016	5	
	dated 12/11/14 o	or diet orders as indicated					
	on her 11/26/15	Physician's Orders did					
	not indicate docu	umentation of the					
	assessed need to	restrict client #3's access					
	to soda or snacks						
	1		1		i e e e e e e e e e e e e e e e e e e e	1	

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Event ID:

HUF211 Facility ID: 000956

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE				
15G442			B. WING 12/09/2015			2015	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0218	12/2/15 at 9:55 Adated 2/5/15, BS orders as indicate Physician's Order documentation or restrict client #4's snacks. 9-3-2(a)	AM. Client #4's ISP AM. Client #4's ISP A dated 11/14/14 or diet ed on her 11/26/15 ers did not indicate of the assessed need to a access to soda or					
Bldg. 00	must include sens Based on observ interview for 1 o the facility failed which corrective	ve functional assessment corimotor development. ation, record review and of 4 sampled clients (#1), d to assess the extent to e, orthotic, or supportive (walker) would impact	W 0	218	W218: The comprehensive functional assessment must include sensorimotor development.		01/08/2016
	group home on 1 through 6:00 PM walker to ambula home.	ere conducted at the 1.2/1/15 from 5:00 PM I. Client #1 utilized a late through the group ere conducted at the 1.2/2/15 from 6:00 AM			Corrective Action: (Specific) Client #1's comprehensive functional assessment will be reviewed specific to sensorime development and results of the assessment will be included in the ISP. Client #1 will be referred back to OT/PT for evaluation of gait and use of walker for ambulation. Any recommendation from OT/PT	otor	

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Event ID:

HUF211 Facility ID: 000956

If continuation sheet Page 4 of 9

STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		15G442				12/09/	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			/ING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	<u> </u>	LISC IDENTIFYING INFORMATION)		TAG			DATE
	_	M. At 6:46 AM, client #1			will be referred to the PCP for		
		e's kitchen area from her			order and will be added to clie	ent	
		#1 ambulated/walked to			#1's ISP. All staff will be		
	the kitchen with	out using a walker. Staff			in-serviced on changes and		
	#1 redirected cli	ent #1 to return to her			implementation of those changes		
	bedroom to retri	eve her walker. Client #1			if any are made.		
	returned to her b	edroom without staff					
	assistance. At 7:	45 AM, client #1					
		itchen area from her			How others will be identified	l:	
	bedroom area without utilizing her				(Systemic): All other client's		
	walker. Staff #1 redirected client #1 to				comprehensive functional		
		lroom to retrieve her			assessments will be reviewed	to	
		1 returned to her			ensure that all identified areas	are	
		yed her walker and			addressed in client program		
	returned to the k				plans. The QIDP will visit the	е	
	leturned to the k	ittellell alea.			home at least twice weekly to		
	IIM (II Mar				ensure that all recommendation	ns	
	,	nager) #1 was interviewed			and training opportunities are		
		38 PM. HM #1 indicated			included in client program pla	ns	
	_	th client #1 should			and staff is following all		
		#1 to utilize her walker			recommendations as written.		
		g in the home. HM #1			The Nurse will visit the home	at	
	indicated staff sl	hould walk/beside client			least weekly to ensure that all		
	#1 while walkin	g in the home without her			recommendations and orders		
	walker. HM #1 i	indicated client #1 should			from outside health care		
	utilize a walker	due to her history of falls.			providers are in place and being	ng	
		-			followed in the home.		
	Client #1's recor	d was reviewed on			Measures to be put in place		
		PM. Client #1's ISP			Client #1's comprehensive	•	
	(Individual Support Plan) dated 5/15/15				functional assessment will be		
	did not indicate documentation of client				reviewed specific to sensorime	otor	
		s use of a walker for			development and results of the		
		ent #1's Physician's			assessment will be included in		
		/2015 did not indicate			the ISP. Client #1 will be		
					referred back to OT/PT for		
	client #1 should	utilize a walker for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
15G442		B. W	ING		12/09/	2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				/ING LN		
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	ambulation Clie	nt #1's OT (Occupational			evaluation of gait and use of		
	Therapy)/PT (Ph	` -			walker for ambulation. Any		
	137	4/3/14 indicated client			recommendation from OT/PT		
					will be referred to the PCP for	an	
		for an unsteady gait. The			order and will be added to clie		
		raluation did not indicate			#1's ISP. All staff will be		
		f recommendations for			in-serviced on changes and		
		ter for ambulation. Client			implementation of those change	es	
	#1's record did n	ot indicate			if any are made.	, -	
	documentation o	f additional OT/PT					
	assessments or re	ecommendations since					
	4/3/14.						
					Monitoring of Corrective		
	Nurse #1 was int	erviewed on 12/2/15 at			Action: All other client's		
		#1 indicated client #1			comprehensive functional		
					assessments will be reviewed t	0	
		for ambulation. Nurse			ensure that all identified areas	are	
		f should encourage client			addressed in client program		
		ker or provide stand by			plans. The QIDP will visit the	:	
	assistance when				home at least twice weekly to		
		without the walker.			ensure that all recommendation	ns	
	Nurse #1 indicat	ed client #1 had a history			and training opportunities are		
	of falls. Nurse #1	l indicated there was not			included in client program plan	ns	
	additional docun	nent of OT/PT			and staff is following all		
	assessment or re-	commendations			recommendations as written.		
	regarding client	#1's ambulation needs.			The Nurse will visit the home	at	
					least weekly to ensure that all		
	Program Manage	er (PM) #1 was			recommendations and orders		
	"	2/2/15 at 1:38 PM. PM			from outside health care		
	#1 indicated clie				providers are in place and bein	g	
					followed in the home.		
	_	ding her ambulation					
	needs.						
	0.2.4(-)				Completion date: 01/08/2016	5	
	9-3-4(a)						

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Event ID:

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A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/09/2015	
402 EV	VING LN		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
W 0263	W263: The committee should insure that these programs are being conducted only with written informed consent of the client, parents (if the client is a minor) or legal guardian. Corrective Action: (Specific) The QIDP will be in serviced cobtaining written informed consent from clients, parents (if client is a minor) or the legal guardian for all psychotropic medications for behaviors. Written informed consent will obtained for psychotropic medications ordered for behaviors from the client, pare (if client is a minor) or legal guardian for clients #1, #2 and #4. How others will be identified (Systemic): All other clients in the home will have their prograplans reviewed to ensure that written informed consent has	e i i i i i i i i i i i i i i i i i i i	
	A. BUILDING B. WING STREET 402 EV JEFFE ID PREFIX TAG	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) W263: The committee should insure that these programs are being conducted only with written informed consent of the client, parents (if the client is a minor) or legal guardian. Corrective Action: (Specific) The QIDP will be in serviced to obtaining written informed consent from clients, parents (iclient is a minor) or the legal guardian for all psychotropic medications for behaviors. Written informed consent will obtained for psychotropic medications ordered for behaviors from the client, pare (if client is a minor) or legal guardian for clients #1, #2 and #4. How others will be identified (Systemic): All other clients is the home will have their prograplans reviewed to ensure that	

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Event ID:

HUF211

Facility ID: 000956

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>		00	COMPLETED		
		15G442	B. WING 12/09/2015			2015	
	.n.o.vvn.nn.o	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			/ING LN		
		LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
		ult. Client #2's BSP			parent (if client is a minor) or		
		#2 received Fanapt			legal guardian for all		
		motrigine (post traumatic			psychotropic medications		
	stress disorder),	Ropinirole (depression)			prescribed for behaviors. The Program Manager will visit the		
	and Seroquel (co	onduct disorder). Client			home at least weekly to ensure		
	#2's record did n	ot indicate			that all psychotropic medication		
	documentation of	of client #2's written			have written informed consent		
	informed consen	t for the use of Fanapt,			from the client, parent (if the	,	
		pinirole or Seroquel for			client is a minor) or legal		
		of client #2's behavior.			guardian.		
	, and management				guardian.		
	3 Client #4's rec	ord was reviewed on			Measures to be put in place:		
		AM. Client #4's ISP			The QIDP will be in serviced		
		icated client #4 was an			obtaining written informed		
					consent from clients, parents (if	
		alt with an advocate.			client is a minor) or the legal		
		dated 11/14/14 indicated			guardian for all psychotropic		
		d Zyprexa (PS (Paranoid			medications for behaviors.		
		Loxitane (PS), Neurontin			Written informed consent will	be	
		oin (PS). Client #4's			obtained for psychotropic		
		dicate documentation of			medications ordered for		
	client #4 or her a	ndvocate's written			behaviors from the client, pare	ent	
	informed consen	t for the use of Zyprexa,			(if client is a minor) or legal		
	Loxitane, Neuro	ntin or Klonopin for the			guardian for clients #1, #2 and		
	management of	client #4's behavior.			#4.		
	Program Manage	er (PM) #1 was					
	-	2/2/15 at 1:38 PM. PM			Monitoring of Corrective		
		facility should obtain			Action: All other clients in the	,	
		d #4 or their individual			home will have their program	_	
		n informed consent prior			plans reviewed to ensure that		
	~	*			written informed consent has		
		chotropic medication for			been obtained by the client,		
	_	of clients #1, #2 and #4's			parent (if client is a minor) or		
	behavior.				legal guardian for all		
					icgai guaithan 101 an		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
		15G442	B. WING		12/09/2015
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				VING LN	
RES CAF	RE COMMUNITY A	ALTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	9-3-4(a)			psychotropic medications	
				prescribed for behaviors. The	
				Program Manager will visit th	
				home at least weekly to ensure	
				that all psychotropic medication have written informed consent	
					l
				from the client, parent (if the	
				client is a minor) or legal	
				guardian.	
				Completion date: 01/08/2010	6

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